

The Health Care Dollar

Some Factors Affecting Costs and Value Received

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HEALTH CARE is probably the biggest industry in the United States, exceeded only by government workers in numbers of people involved. The combined worker aggregate of the automobile, aircraft and steel components of the national economy is less than that of the health care industry.¹ Looked at another way, medical care is a service industry which requires a large number of people to provide optimal health benefits. The cost of services is largely represented by salaries, and it is true that, at this time, the service component of the Consumer Price Index is rising faster than other components.

Distribution and Source of Health-Care Money

Studies vary somewhat as to distribution of the health-care dollar. Two sources, Hewitt Associates² and the 1966 *Source Book of Health Insurance*,³ roughly apportion 90 percent of the national health-care dollar to hospital services, physician and other professional services, and to drugs and appliances. Just under 30 percent of the health-care dollar goes to physicians for their professional services (Chart 1). Where does the money come from? Sixty-five percent comes from private sources. Thirty-four percent comes from public sources, with this percentage steadily increasing.

Health insurance has rapidly expanded and serves an increasing percentage of our national population (Chart 2).³ This is in part due to or-

ganized labor's very proper concern for the health needs and care of members. While this degree of market penetration is a good sign, not all insurance policies are good, since they tend to vary

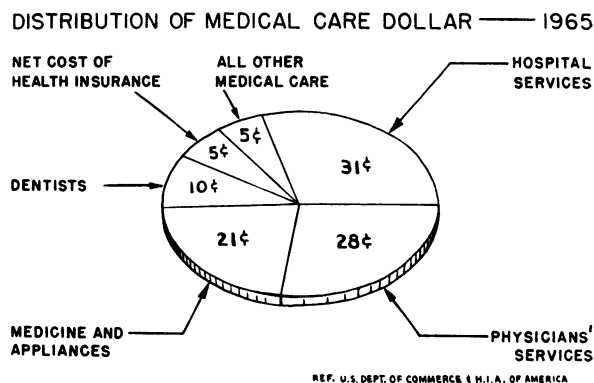


Chart 1.—Distribution of Medical Care Dollar in 1965.

PERCENTAGE OF UNITED STATES POPULATION* WITH SOME FORM OF HEALTH INSURANCE PROTECTION — 1940-1965

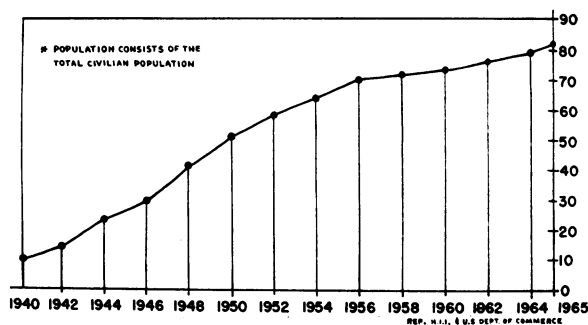


Chart 2.—Percentage of total civilian population with some form of health insurance.

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GROWTH OF HOSPITAL, SURGICAL AND REGULAR MEDICAL EXPENSE PROTECTION

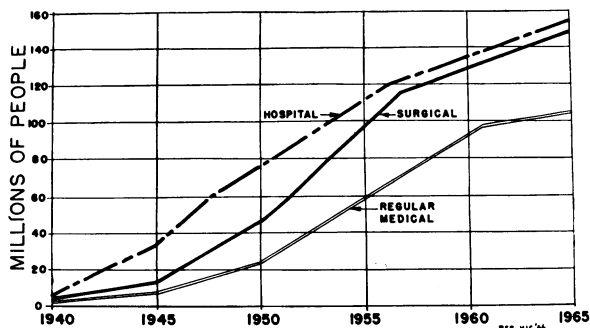


Chart 3.—Comparison of degree of market penetration of policies providing hospital, surgical, and regular medical expense protection.

rather widely in the scope of benefits they provide, and medical expense protection still lags between hospital and surgical coverage (Chart 3).⁴ Some programs do not include adequate deterrent against abuse, and may, because of limitations in coverage, encourage abuse such as overuse of hospitalization for purely diagnostic services. At this time there is considerable talk of "first dollar coverage." Any first dollar coverage entails a large expense for claim processing. Twenty-six percent of health cost expenditures are accounted for by 60 percent of our population who have yearly medical bills of less than \$100. It does not appear unreasonable that most individuals who have health insurance as part of a fringe benefit or as an individually purchased policy, could afford a \$100 a year deductible coverage. As people obtain greater security against the unpredictable expense of illness or accident, the rate of utilization of medical services, both in the physician's office and in hospitals, increases. The inclusion of a deductible provision in all policies appears to make fiscal sense, not only

THE PHYSICIAN FEE INDEX IN THE UNITED STATES AND CALIFORNIA — JUNE 1962—DECEMBER 1967

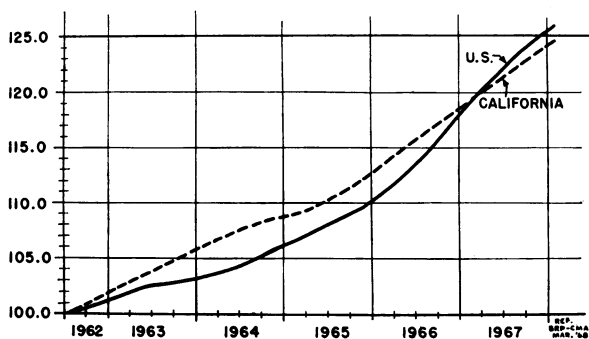


Chart 5.—The physician fee index in the United States and California—June 1962—December 1967.

MEDICAL CARE PRICES

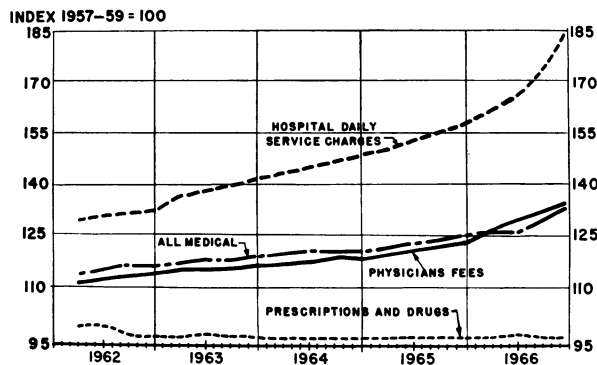


Chart 4.—A comparison of the increase in hospital charges compared with physician charges. (Note that in 1966 alone hospital costs rose 12 percent whereas physician fees showed the same increase as in preceding years, 5 percent.)

by effecting some controls of over-utilization, but also by lessening administrative expenses.

Physicians' control over the hospital cost of illness is limited. It is true that they do have appreciable control over hospital utilization, but they have practically no control over gross hospital charges, 65 percent of which are related to personnel salaries. Hospital costs have increased more rapidly than physicians' fees² (Chart 4). More important is the fact that hospital prices have increased 41 percent from 1962 through 1966, a five-year period, while physicians' fees have increased 18.8 percent during that time, that is, at an annual rate of less than 4 percent. Figures compiled by the Bureau of Research and Planning of the California Medical Association bear out the fact that the long-term increase rate in physicians' fees in California has been approximately the same as that indicated for the total United States. Within the past two years, however, there are indications that the rate of increase has been somewhat lower in California than in the nation, according to the Bureau's findings. (Chart 5.)⁵

Some critics combine the average of physician and hospital costs as an index of cost of medical care. This is misleading, because such grouping provides only a mean index of medical costs and doesn't separate the components. Other critics of the medical profession relate physicians' fees to the Consumer Price Index. This method of comparison is not entirely valid, since no index includes a device for measuring quality improvement. The likelihood of quality improvement in medical care can only be measured by the "greater probability

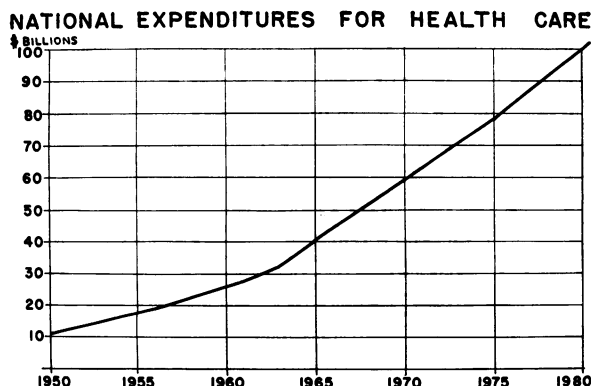


Chart 6.—Health care expenditures projected to the year 1980.²

today that an individual's health will benefit from a physician's service."¹

There is no question that medical costs are increasing. The average medical expense of a family unit of four, including dental care, was almost \$400 in 1965 and it is estimated that this will approach \$750 in 1975. By the year 1975 national health expenditures will probably be in excess of \$70 billion. By 1985 it is varyingly estimated that these costs will be between \$110 billion and \$122 billion (Chart 6).

Analysis of Cost Increases

Now, one may properly ask, "Why this increase?" One factor is the increased time spent with the patient which is necessary for a better patient-physician relationship and to improve medical care. Statistics are not available to permit objective appraisal of the hypothesis that present-day medical practice is not only technically more difficult and time-consuming, but must also relate to the changing social environment. Patients expect more from their physicians, and are also quicker to sue the physician and hospital. One cannot be both efficient in time-saving and still devote the appropriate time with patients that today's standards of care demand.

Let us analyze some of the other factors which brought about the increase in medical expenditures between 1950 and 1965.² Chart 7 shows that there are a number of additional components in the 1965 medical cost column which reflect not only the obvious, such as population increase, general inflation, and—much as one may dislike the term—"medical care inflation." But there is also an appreciable element in this increase which is related to greater use of services, the availability of new services due to advances in medical technology, the

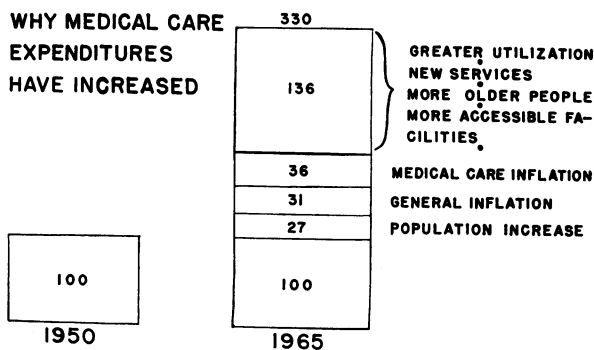


Chart 7.—Why medical care expenditures have increased.²

effect of the increased average age of the population, and the availability and accessibility of medical care and facilities.

What Does the Future Hold?

There is an obvious need for all elements of the medical care industry to cooperate in an effort to improve efficiency of operation without lessening in any way the quality of medical care. Can physicians profit by improved office design, by the best use of modern facilities and equipment, by the best possible use of assistants and aides, and by the proper use of modern production and design engineering?

Should hospitals be massive and expensive monuments to organizations or individuals when medical technology is advancing so fast that even the most modern hospital becomes virtually obsolete after 15 years or so? Should we not consider a change in attitude about hospital construction? Why not accept in-built obsolescence and effect first-dollar cost savings so that we can rebuild hospitals every 15 years?

Should not hospitals operate completely and fully for six, or even seven days a week, through cooperation with organized medicine? Physicians and hospital personnel could stagger their on-duty and off-duty time to permit an expanded work-week of this type. This would decrease, if not eliminate, the present invariable decline in weekend hospital occupancy, would shorten length of stay, and would also accomplish economies in other areas of hospital operation. Such a plan has been successfully tested.⁶

The medical profession's answer to criticism should not be defensive, nor should it imply that further escalation in cost is totally beyond control and inevitable. Physicians can be constructive and attempt to identify areas where runaway costs can

be controlled. Under optimal circumstances, improving the efficiency with which medical care is provided could reduce costs or at least hold them constant for some period. Is it imprudent to suggest that hospitals might even become competitive—not in bricks and mortar, cobalt therapy or open-heart surgery—but rather in efficiency and economy both in construction and operation? This could then be reflected by a lower per diem charge. Certainly physicians and hospitals must work together to implement those changes which would lessen cost yet maintain or improve the quality of care provided. There are those who feel that the social economics of the medical care industry are hopelessly obsolete. Some of these critics recommend change⁵ which could be detrimental to the

quality of care. If planning is left to government, one can foresee further manpower drains on already limited personnel resources. It is not too late for medicine to become productively involved in this problem, but not much time is left.

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CERVICAL EXTENSION OF ENDOMETRIAL CARCINOMA

"Since 1958 we have combined radiation with radical surgery in patients [with endometrial carcinoma] in whom fractional curettage has demonstrated cervical extension; and this has constituted approximately 15 percent of the patients treated. . . . In the remaining group where fractional curettage has not demonstrated cervical extension, we have not utilized intravaginal radiation — either therapeutically or prophylactically. In going over the material from 1958 through the present, we are pleased to report that we have not had a single recurrence in the vaginal wall in either series.

"This suggests to us that perhaps by utilizing a fractional curettage as a routine diagnostic measure in the evaluation of women with endometrial carcinoma, you may have a measure of being more selective in the patient who is going to receive routine intravaginal radiation. It's of interest, I think, that the more or less conventional incidence of so-called vaginal cuff recurrence — approximately 15 percent — is quite comparable to the incidence of cervical extension in endometrial carcinoma."

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